Immunoglobulin (IG)

IV & SubQ Orders

Advanced Infusion Care Centers

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies ☐ See List ☐ NKDA City, State, Zip: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ in ☐ cm Email: _____

PRIMARY DIAGNOSIS

☐ ICD-10 Code (required): _____

PRESCRIPTION

Pharmacist or Infusion Center Provider to identify clinically appropriate brand/infusion rates. May substitute based on product availability.

Loading Dose (as applicable) ☐ IV ☐ SubQ	_____	☐ mg/kg ☐ gm/kg ☐ grams	X ____ day(s) OR divided over ____ day(s)	☐ One time dose ☐ Other: _____ *Give maintenance dose ____ weeks after loading dose*
Maintenance Dose ☐ IV ☐ SubQ	_____	☐ mg/kg ☐ gm/kg ☐ grams	X ____ day(s) OR divided over ____ day(s)	☐ Every ____ weeks x 1 year ☐ Other: _____

☐ Do not substitute. Administer brand: _____

- Infuse entire contents of IG infusion bag/vial(s) per current dose
- If needed, round dose to nearest whole 5grams vial for IV doses and nearest single-use vial size for subQ doses

First Dose ☐ Yes ☐ No ☑ Refill x 12 months unless otherwise noted: _____

Pre-Medication Orders: to be administered 15-30 minutes prior to infusion

☐ Acetaminophen 500mg PO ☐ Loratadine/Cetirizine 10mg PO ☐ Other: _____

☐ Normal Saline 500mL IV ☐ Diphenhydramine 25mg PO

☐ Solu-medrol _____IV ☐ Diphenhydramine 25mg IV

REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Demographics
- Medication List
- Most recent labs
- Current IG levels

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol. *(See aiscaregroup.com for detailed policy)*

☐ Other: Please fax other reaction orders if checking this box

LINE CARE ORDERS (FOR IVIG)

☑ Start PIV/Access CVC ☑ Flush device per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*

☐ Other Flush Orders: Please fax other line care orders if checking this box

LAB ORDERS—PLEASE INCLUDE FREQUENCY

☐ Please list any labs to be drawn by the infusion clinic: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.